history of epigastric abdominal pain and fresh red blood hematemesis. She denied having melena or bloody stools but complained of low back pain for the last week for which she has been using over-the-counter ibuprofen. Upon presentation, her vital signs were normal and her examination was remarkable for epigastric tenderness and small ecchymosis on her legs. Upon admission, laboratory studies, including complete blood count, serum electrolytes, liver enzymes, and serum amylase and lipase were normal except an INR value of 9.1. She underwent an EGD procedure that revealed antral gastritis but no source of active bleeding was found at the time so ibuprofen induced gastritis was the presumed etiology for her symptoms and she was admitted to the intensive care unit for close monitoring and treatment with IV proton pump inhibitor as well as fresh frozen plasma transfusion. Few hours later, the patient started to complain of diffuse severe abdominal pain with concomitant drop in hematocrit level so abdomen and pelvis CT scan was performed that revealed jejunal wall thickening and intra-pelvic free fluid collection, raising the suspicion of jejunal intramural hematoma. Red blood cell transfusion was started and surgery was consulted who proceeded with exploratory laparotomy with resection of 70 cm of the jejunum as well as draining the intra-pelvic blood. The patient was observed in the hospital after the surgery and her INR dropped down to normal and she didn’t have any more abdominal pain or further bleeding.

**Results:** With a reported incidence of 1 per 2500 patients with anticoagulation, spontaneous intramural hematoma is considered a rare entity with the jejunum being the most common site of involvement, although it can affect any part of the gastrointestinal tract. It mainly affects older adults with the mean age at presentation in one series was 64 years. The presentation ranges from mild vague symptoms to an acute abdomen picture. While many patients may have concomitant upper GI hemorrhage, as in our patient, it was noted that many other patients lack this finding. CT-scan remains the imaging modality of choice although ultrasound and upper GI series were found to be helpful in making the diagnosis preoperatively. Conservative management with correction of coagulation parameters leads to spontaneous resorption of the hematoma in most cases and surgery should be reserved for patients with signs of bowel necrosis, rupture, or the development of frank peritonitis.

**Incidental Asymptomatic Right Sided Paraduodenal Hernia: A Rare Congenital Anomaly**

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**Purpose:** Paraduodenal hernia is a very rare congenital anomaly, accounting for half of all internal hernias. Small bowel gets entrapped in a peritoneum-lined sac behind the mesocolon. We present one of the first incidentally diagnosed asymptomatic case of right paraduodenal hernia. A 50-year old female with chronic hepatitis C genotype 3 with an elevated alpha fetoprotein level of 16.32 IU/ml on routine work up underwent a CT abdomen to look for liver lesions. Incidentally seen was a right paraduodenal hernia. Patient was asymptomatic with normal physical exam. Surgical correction was offered but patient refused. Right paraduodenal hernia results from failure of complete midgut rotation during embryogenesis with resultant small bowel entrapment on the right side behind the mesocolon. Left paraduodenal hernia is more common and herniates through a defect in the descending mesocolon into the fossa of Landzert. Repeated herniation increases defect size, leads to adhesions, obstruction or strangulation. Clinical findings vary from mild intermittent abdominal complaints to acute obstruction, volvulus and infarction. On CT left paraduodenal hernia is seen as a saddle-shaped cluster of small bowel loops in the left upper quadrant between pancreatic body-tail and stomach, displacing the inferior mesenteric vein anterolaterally. With right paraduodenal hernia, small bowel loops lie on the right behind the superior mesenteric vessels, below the transverse portion of the duodenum displacing the right colic vein anteriorly. Other findings include mass effect on posterior stomach wall, engorgement and crowding of mesenteric vessels at mouth of hernial sac, depression of transverse colon and small bowel obstruction. Upper GI series may show entire small bowel to one side of the abdomen. Diagnosis is by clinical and radiographic findings. Management is by surgical repair. In conclusion paraduodenal hernia, especially right sided hernia is extremely rare causing internal bowel entrapment on the right side behind the mesocolon. Left paraduodenal hernia. Patient was asymptomatic with normal physical exam. Surgical correction was offered but patient refused. Right paraduodenal hernia results from failure of complete midgut rotation during embryogenesis with resultant small bowel entrapment on the right side behind the mesocolon. Left paraduodenal hernia is more common and herniates through a defect in the descending mesocolon into the fossa of Landzert. Repeated herniation increases defect size, leads to adhesions, obstruction or strangulation. Clinical findings vary from mild intermittent abdominal complaints to acute obstruction, volvulus and infarction. On CT left paraduodenal hernia is seen as a saddle-shaped cluster of small bowel loops in the left upper quadrant between pancreatic body-tail and stomach, displacing the inferior mesenteric vein anterolaterally. With right paraduodenal hernia, small bowel loops lie on the right behind the superior mesenteric vessels, below the transverse portion of the duodenum displacing the right colic vein anteriorly. Other findings include mass effect on posterior stomach wall, engorgement and crowding of mesenteric vessels at mouth of hernial sac, depression of transverse colon and small bowel obstruction. Upper GI series may show entire small bowel to one side of the abdomen. Diagnosis is by clinical and radiographic findings. Management is by surgical repair. In conclusion paraduodenal hernia, especially right sided hernia is extremely rare causing internal herniation of the jejunal loops that can progress to bowel obstruction or strangulation without surgery.

**Carcinoid Tumor Presenting as Recurrent Small Bowel Obstruction**

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**Purpose:** Carcinoid tumors are rare neuroendocrine tumors with secretory properties. They are slow growing malignant neoplasms but can act aggressively. Carcinoid syndrome may manifest as a syndrome related to the secretory properties of the tumor. Symptoms of carcinoid syndrome usually consist of flushing, sweating, diarrhea and bronchospasm. Carcinoid tumors of the small intestine comprise approximately one third of small intestine neoplasms. Patients with carcinoid of the small intestine will commonly present with abdominal pain and chronic progressive bowel obstruction if they have metastases to the lymph nodes. We present a rare case of a patient with carcinoid tumor who presented with recurrent bowel obstruction. The patient is an 82 year old gentleman who presented with recurrent abdominal distension and abdominal pain. There was no history of melena, hematemesis, vomiting of feculent or bilious material, fever, chills or weight loss. He did not complain of any flushing, sweating or diarrhea. He had no significant past medical history and no prior history of abdominal surgery. The patient denied taking any medications and denied any alcohol, smoking or drug history. The patient was afebrile and had stable vital signs on admission. On physical exam, the abdomen was markedly distended with periumbilical and right lower quadrant tenderness to palpation. There was no rebound tenderness and no masses were palpable. Bowel sounds were present and were not hyperactive. Rectal examination was normal. His laboratory findings on CBC, chemistry and liver function tests were all within normal limits. An X-ray of the abdomen showed multiple air fluid levels consistent with partial small bowel obstruction. This was confirmed on CT scan, which showed distended loops of small bowel and multiple liver lesions were also noted. A liver biopsy was performed for diagnostic purposes. Pathology revealed swirls of neuroendocrine cells consistent with carcinoid tumor. The patient was managed conservatively, kept NPO and was treated with intravenous somatostatin analogues. The patient’s symptoms improved and his diet was advanced and he was eventually discharged home and is currently doing well. Although carcinoid tumors are occasionally seen in the gastrointestinal tract and can present with a myriad of GI symptoms, recurrent bowel obstruction is a rare presenting finding. This case demonstrates that when a patient presents with recurrent episodes of intermittent bowel obstruction, carcinoid tumor should be considered as part of the differential diagnosis.

**Expanding Diagnostic Role of Double Balloon Enteroscopy**

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**Purpose:** Introduction Double Balloon Enteroscopy (DBE) is a relatively new endoscopic modality. Its initial application was as a means to image the